Evolving Healthcare Issues: Osteoporosis, Diabetes, and Prostate Cancer

Guide to Medicare Billing: Bone Density Studies, Diabetes Outpatient Self-Management Training Services, and Prostate Screening Services

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Evolving Health Care Issues: Osteoporosis, Diabetes, and Prostate Cancer

Introduction

Every year the statistics improve. Some diseases, such as certain types of cancer—including prostate cancer—are now being discovered in the early stages, where they can be successfully treated and possibly even cured.

Patient education plays a major role in the good news. Research has shown that very often the most important way to promote early detection is through the physician or other health care professional. Physicians can stress the need for prevention and early detection that can improve a person's quality of life. For example, patients with diabetes can learn to control their lives by controlling their disease. In other diseases, such as osteoporosis, tests can alert patients to their risk of disease, enabling them to make lifestyle choices that may reduce or alter that risk.

This national focus on prevention and early detection has resulted in a higher level of consumer interest in preventive medicine, including Medicare preventive benefits.

HCFA's dual-pronged comprehensive training program promotes awareness and increased use of these proactive Medicare benefits. The program assists health care providers to build their practices by promoting wellness and explains billing requirements.

A national satellite broadcast is a key element in this program. The primary focus of this broadcast is to increase awareness and use of various services relating to the prevention and stabilization of certain diseases. It brings together experts from the National Osteoporosis Foundation (NOF), American Cancer Society (ACS), American Urologic Association, and the Johns Hopkins University Diabetes Center, along with other medical experts and public figures.

To complement the satellite broadcast, this resource booklet discusses Medicare coverage and billing guidelines for several preventive services—bone density studies, prostate screening antigen (PSA) blood test, and digital rectal examination (DRE)—and describes diabetes outpatient self-management training services. Billing requirements to assist in effective claims filing are also discussed.

It is hoped that the national satellite broadcast and this resource booklet will be useful additions to every health care professional's Medicare tool kit.

Osteoporosis

Bone Density Studies

What are Bone Density Studies?

The term "bone mass measurement" is synonymous with "bone density study." It is defined as a radiological or radioisotope procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss or determining bone quality. Bone density studies are used to evaluate diseases of the bone and/or the responses of bone disease treatment; they include a physician's interpretation. The studies assess bone mass or density associated with such diseases as osteoporosis and other bone abnormalities. Various single and combined methods of measurement may be required to diagnose bone disease, monitor the course of bone changes with disease progression, or monitor the course of bone changes with therapy. Bone density is usually studied by using photodensitometry, single or dual photon absorptiometry or bone biopsy.

Bone density can be measured at the wrist, spine, hip, or calcaneus. The medical literature is divided on the accuracy of predicting osteoporosis of the spine or hip by measuring peripheral sites (wrist, calcaneus). It does appear, however, that bone density measurement of the involved bone gives a better measurement of osteoporosis than does measurement of another bone not known to be involved.

Standardizing Bone Density Studies

One concern with bone density testing is a lack of standardization that results in inconsistent test results. Tests should be done on the same suitably precise instrument, to ensure accuracy; but, because systematic differences among scanners have been found, it is also important to use results obtained with the same *type* of scanner, when comparing a patient to a control population. To ensure reliability of bone mass measurements, the densitometry technologist must have proper training in performing this procedure. Malpositioning of the patient or incorrect analysis of a scan can lead to major errors in bone density studies. In addition, precise calibration of the equipment is required for accuracy and to reduce variation of test results and risk of misclassification of the degree of bone density.

Bone Density Studies Coverage Guidelines

The Balanced Budget Act of 1997 provided for standardization of Medicare coverage of bone mass measurements. This standardized coverage is effective for claims with dates of service on or after July 1, 1998.

Bone density studies are covered for patients with any one of the following indications:

- a patient with vertebral abnormalities, as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture
- a patient being monitored to assess the response to or efficacy of an FDA approved osteoporosis drug therapy
- a patient with known primary hyperparathyroidism
- a patient receiving (or expecting to receive) corticosteroid therapy (greater than three months or the equivalent dose of 30 mg cortisone [or 7.5 mg prednisone] or greater per day)
- a woman who is estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings

In addition, all coverage criteria listed below must be met:

- The individual's physician or qualified non-physician practitioner treating the patient must provide an order, following an evaluation of the need for a measurement that includes a determination as to the medically appropriate measurement to be used for the individual.
- The service must be furnished by a qualified supplier or provider of such services under at least the general level of physician supervision.
- The service must be reasonable and necessary for diagnosing, treating, or monitoring an individual as defined above.
- The service must be performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the FDA for bone mass measurement purposes, with the exception of dual photon absorptiometry devices.

Statutory Required Frequency Parameters

Medicare may cover a bone mass measurement for a patient once every two years (if at least 23 months have passed since the month the last bone mass measurement was performed). However, if medically necessary, Medicare may cover a bone mass measurement for a patient more frequently than every two years. Examples of situations where more frequent bone mass measurement procedures may be medically necessary include, but are not limited to, the following medical conditions:

- monitoring patients on long-term glucocorticoid (steroid) therapy of more than three months

- allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit future monitoring of a patient, if the initial test was performed with a different technique than the proposed monitoring method. For example, if the initial test was performed using bone sonometry, and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement using bone densitometry).

Types of Densitometers

Medicare provides coverage for the following types of densitometers:

- **Stationary**: a device that is permanently located in an office
- **Mobile**: a device that is transported by vehicle from site to site
- **Portable**: a device that can be picked up and moved from one site to another

Procedure Codes and Descriptors

Bone density studies are performed to establish the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture. Bone densitometry includes the use of single photon absorptiometry (SPA), single energy X-ray absorptiometry (SEXA), dual photon absorptiometry (DEXA), quantitative computed tomography (QCT), and bone ultrasound densitometry (BUD).

The following HCPCS/CPT codes have been established for reporting of peripheral and central DEXA studies:

G0130	**Single energy X-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)**
G0131	**Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)**
G0132	**Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)**
76075	**Dual energy X-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)**
76076	**Dual energy X-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)**
76078	**Radiographic absorptiometry (photodensitometry), one or more sites**
76977	**Ultrasound bone density measurement and interpretation, peripheral site(s), any method**
78350	**Bone density (bone mineral content) study, one or more sites; single photon absorptiometry**

Diagnosis Requirements

Contact the Medicare carrier or intermediary in your state for specific diagnosis codes that are payable for bone density studies.

Coding Tips

When billing Medicare for bone density studies, the following tips should be considered:

- A bone density study procedure code should be billed only once, regardless of the number of sites being tested or included in the study (e.g., if the spine and hip are performed as part of the same study, only one can be billed).

- For claims with dates of service on or after January 1, 1999, CPT code 76977 replaces HCPCS code G0133, which was discontinued December 31, 1998.

Documentation Requirements

Medical record documentation maintained by the treating physician must clearly indicate the medical necessity for ordering bone density studies. The documentation may be included in any of the following:

- history and physical
- office notes
- test results with written interpretation
- X-ray/radiology with written interpretation

Payment Requirements for Carriers

Reimbursement of bone mass measurements is made on the basis of the Medicare physician fee schedule. Deductible and co-insurance are applicable. Claims from physicians, non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge.

Payment Requirements for Intermediaries

When billing using the HCFA-1450 or electronic equivalent, the following billing requirements should be considered:

- **Applicable Bill Types.** The appropriate bill types are 12X, 13X, 14X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X and 85X. Providers utilizing the UB-92 flat file use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required. Providers utilizing the hard copy UB-92 (HCFA-1450) report the applicable bill type in Form Locator (FL) 4 "Type of Bill."

- **Coding Requirements.** Providers must report HCPCS/CPT codes for bone mass measurements under revenue code 320. In addition, they must report the number of units, and line item dates of service per revenue code line for each mass measurement reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998. Providers utilizing the UB-92 flat file use record type 61 to report the bone mass procedure. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), revenue code 320 (Field No. 4), HCPCS code, as appropriate (Field No. 5), units of service (Field No. 8), date of service (Field No. 12) and outpatient total charges (Field No. 10) are required. Providers utilizing the hard copy UB-92 (HCFA-1450) report the appropriate HCPCS/CPT code in FL 44 "HCPCS/Rates," and revenue code 320 in FL 42 "Revenue Code." The date of service is reported in FL 45 "Service Date" (MMDDYYYY), and the number of service units in FL 46 "Service Units."

Bone mass measurements will be reimbursed under current payment methodologies for radiology services. Part B deductible and co-insurance are applicable.

Reasons for Denial

Following are some reasons that Medicare may deny bone density studies:

- when performed for indications other than those listed under the *"Coverage Guidelines"* section

- when the appropriate physician or qualified non-physician practitioner does not order tests. For purposes of this provision, a physician or qualified non-physician practitioner is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient.

- bone density studies of any type, including DEXA scans, are not covered under the portable X-ray benefit. The benefit allows X-ray films of the skeleton, chest, or abdomen. Although bone density studies are radiology procedures, they are not X-ray films. In addition, the portable X-ray service benefit requires that equipment be portable enough to provide services at home.

- when submitted with diagnosis codes that are not payable for the procedure (if applicable).

Note: CPT **78351 (Dual Photon Absorptiometry)** is non-covered by Medicare Coverage Issues Manual 50-44. (This procedure should not be reported under CPT codes 76075 or 76076).

Unique Physician Identification Number (UPIN) Requirements

Any service that is ordered or referred by a physician requires the ordering/referring physician's name and UPIN in blocks 17 and 17a on Form HCFA-1500. If submitting electronically, the UPIN of the ordering/referring physician goes in record FB1, field 13, and the name goes in record FB1, fields 10, 11, and 12.

Diabetes

Diabetes Outpatient Self-Management Training Services

What are Diabetes Outpatient Self-Management Training Services?

Section 4105 of the Balanced Budget Act of 1997 (BBA) permits Medicare coverage of diabetes outpatient self-management training services, effective July 1, 1998, when these services are furnished through a certified program that meets certain quality standards. [1]

A diabetes outpatient self-management and training program should educate beneficiaries in the successful self-management of diabetes. The training program should include:

- education on self-monitoring of blood glucose
- education on diet and exercise
- an insulin treatment plan developed specifically for the insulin-dependent patient
- motivational sessions to encourage patients to use learned skills for self-management of their diabetic condition

Outpatient self-management training services may be covered under Medicare only if the physician managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care. This plan of care must be related to the beneficiary's diabetic condition to ensure therapy compliance, or to provide the individual with the necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to successfully manage his/her condition.

Certified Training Programs

To provide diabetes outpatient self-management training services, the Health Care Financing Administration considers a certified training program to be one that is conducted by:

- physicians, individuals, or entities paid under the physician fee schedule and meeting National Diabetes Advisory Board (NDAB) standards

[1] HCFA is currently reviewing this benefit and final regulations are scheduled for publication around August 2000. Providers should be aware that both coverage and reimbursement guidelines may be affected.

- other non-physician practitioners whose services are paid for under the physician fee schedule and who meet NDAB standards. These non-physician practitioners include physician assistants (PAs), nurse practitioners (NPs), nurse midwives (NMs), clinical psychologists (CPs), and clinical social workers (CSWs).

Note: *Providers are responsible for ensuring that their programs are National Diabetes Advisory Board (NDAB) certified. A list of NDAB standards is included later in this section.*

In keeping with the requirements of the legislation, services provided by individuals other than physicians are covered when the services are provided within the current coverage requirements. These services may be provided in two ways:

- Services performed by non-physician practitioners may be incident to a physician's professional services; however, even if incidental, they must be integral to the physician's personal professional services, and they must be performed under the physician's direct personal supervision.

- A non-physician practitioner such as a physician assistant or nurse practitioner may be licensed under state law to perform a specific medical procedure. This practitioner may also be able to perform the procedure without physician supervision and have the services separately covered and paid for directly by Medicare as physician's assistant or nurse practitioner services. Medicare only covers procedures and services that are performed in accordance with state licenses.

Provider Certification

In order for a provider to bill Medicare for diabetes outpatient self-management training services, he/she must meet all of the following National Diabetes Advisory Board (NDAB) standards and must be recognized by the American Diabetes Association.

I. STRUCTURAL STANDARDS:

A. Organizational support by sponsoring organization

Standard 1: Maintain written policy-affirming education as integral component of diabetes care.

Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget, and instructional materials.

Standard 3: Clearly define and document organizational relationships, lines of authority, staffing, job descriptions, and operational policies.

B. Community needs assessment

Standard 4: Assess service areas to define target population and determine appropriate allocation of personnel and resources.

C. Program management

Standard 5: Establish standing advisory committee including at least a physician, nurse educator, dietitian, behavioral science expert, consumer, and community representative to oversee the program.

Standard 6: The advisory committee should participate in annual planning to determine target population, program objectives, participant access, and follow-up mechanisms, instructional methods, resource requirements, and program evaluation.

Standard 7: Professional program staff should have sufficient time and resources for lesson planning, instruction, documentation, evaluation, and follow up.

Standard 8: Assess community resources periodically.

D. Program staff

Standard 9: Designate a coordinator responsible for program planning, implementation, and evaluation.

Standard 10: Program instructors should include at least a nurse educator and dietitian with recent didactic and experiential training in diabetes clinical and educational issues.

Certification as diabetes educator by the National Certification Board of Diabetes Educators is recommended.

Standard 11: Professional program staff should obtain continuing education about diabetes, educational principles, and behavioral change strategies.

E. Curriculum

Standard 12: The program must be capable of offering, based on target population needs, instruction in the following 15 content areas:

- diabetes overview
- stress and psychosocial adjustment
- family involvement and social support
- nutrition
- exercise and activity
- medications
- monitoring and use of results
- relationships among nutrition, exercise, medication, and glucose levels
- prevention, detection, and treatment of acute complications
- prevention, detection, and treatment of chronic complications

- foot, skin, and dental care
- behavior change strategies, goal setting, risk factor reduction, and problem solving
- benefits, risks and management options for improving glucose control
- preconception care, pregnancy, and gestational diabetes
- Use of health care systems and community resources

Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.

Standard 15: The program must be conveniently and regularly available.

Standard 16: The program must be responsive to requests for information and referrals from consumers, health professionals, and health agencies.

II. PROCESS STANDARDS

A. Assessment

Standard 17: Develop and update an individualized assessment for each participant, including medical history and health status; health services utilization; risk factors; diabetes knowledge and skills; cultural influences; health beliefs, attitudes, behavior and goals; support systems; barriers to learning; and socioeconomic factors.

B. Plan and Implementation

Standard 18: Develop an individualized education plan, based on the individualized assessment, in collaboration with each participant.

Standard 19: Document the assessment, intervention, evaluation, and follow-up for each participant, and collaboration and coordination among program staff and other providers, in a permanent record.

C. Follow up

Standard 20: Offer appropriate and timely educational intervention based on periodic reassessments of health status, knowledge, skills, attitude, goals, and self-care behaviors.

III. OUTCOME STANDARDS

A. Program

Standard 21: The advisory committee should review program performance annually, and use the results in subsequent planning and program modification.

B. Participant

Standard 22: The advisory committee should annually review and evaluate predetermined outcomes for program participants.

Providers that bill Medicare for diabetes outpatient self-management training services must meet all of the NDAB standards and must be recognized by the American Diabetes Association.

Billing Requirements

Before billing for diabetes outpatient self-management training services, all providers must submit to the Medicare contractor an Education Recognition Program (ERP) certificate from the American Diabetes Association (ADA). The ERP certification should be sent to the local contractor's provider enrollment department.

To avoid delays in payment for services, a cover letter and Provider Identification Number (PIN) must be included with the ERP certificate. Note: Multiple providers in a group setting must submit individual copies of the ERP certificate with a cover letter and his/her individual PIN. Individuals or entities interested in obtaining an ERP certificate should contact the American Diabetes Association National Office at 1-888-232-0822. A certificate of recognition from the ERP ensures that the recognized educational program has met the National Diabetes Advisory Board Standards.

Billing Guidelines for Non-Physician Practitioners

Employers of physician assistants (PAs) must bill Medicare Part B for professional services furnished by the PA, as well as services furnished as incident to the professional services of a PA. The PA's supervision physician (or a physician designated by the supervision physician or employer as provided under state law or regulation) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. Pursuant to section 4512 (c) of the BBA, Medicare payment for PA services is made only to the PA's employer, regardless of the PA's status as a W-2 employee or an independent contractor. Also, while a PA has an option in terms of selecting employment arrangements, only the employer can bill a carrier or intermediary for the PA's services.

Any service furnished by a PA must be furnished under the general supervision of a physician. General supervision does not require the physician to be present on the premises and immediately available while all services are being furnished. Rather, the physician may be reached by telephone in case of an emergency. However, any services furnished incident to the professional services of the PA must be furnished while the PA is present on the premises and immediately available in case of an emergency while these ancillary services are being furnished. Accordingly, any services furnished incident to the professional service of a PA must comply with all of the "incident to" requirements mentioned above.

Clinical nurse specialists (CNSs) and nurse practitioners (NPs) may bill Medicare Part B directly for services performed in collaboration with a physician. They may also bill the program directly for services furnished incident to their professional services; in that case, the direct supervision requirement and all the "incident to" requirements apply.

HCFA requires CNSs, NPs, and employers of PAs to submit claims to the Part B carrier, under their own respective billing numbers, for their professional services furnished in facilities or other provider settings. The only exception would be in a case where the services of these non-physician practitioners are furnished to patients in rural health clinics (RHCs) and federally qualified health centers (FQHCs). Payment for the services of these non-physician practitioners in the RHC/FQHC setting is bundled under the facility cost payment made by the intermediary under the all-inclusive rate.

Procedure Codes and Descriptors

The following HCPCS codes have been established for outpatient diabetes self-management training services:

G0108 **Diabetes outpatient self-management training services, individual, per session**

G0109 **Diabetes outpatient self-management training services, group session, per individual**

Coding Tips

- Services for diabetes outpatient self-management training must be billed with the appropriate HCPCS code G0108 or G0109, in one-hour increments only. If the training session lasts 90 minutes, only 60 minutes can be billed for that session.

- Billing an evaluation and management code is not mandatory before billing the diabetes outpatient self-management training procedure codes.

- The number of patients in a group does not need to be identified when billing for procedure code G0109.

- Claims received prior to submitting ERP certification or for services performed outside of the certification period will be denied payment. Appeal rights will not be honored. Providers are encouraged to re-file denied claims after receiving notification from their contractor's provider enrollment department that the ERP certification has been received and their files have been updated to reflect the ERP certification information.

- Diabetes outpatient self-management training services rendered in an FQHC or an RHC setting by a non-physician practitioner will be denied payment, since the payment to the facility covers the charges for the professional services of NPs, PAs, and CNSs.

Payment Requirements for Carriers

Reimbursement of diabetes outpatient self-management training services is made based on the Medicare physician fee schedule. Deductible and co-insurance apply. Claims from physicians, non-physician practitioners, or suppliers where assignment was not taken are subject to Medicare's limiting charge.

Payment Requirements for Intermediaries

When billing using Form HCFA-1450 or the electronic equivalent, the following billing requirements should be remembered:

- **Applicable Bill Types.** The appropriate bill types are 11X, 12X, 13X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X and 85X.

- **Coding Requirements.** Providers must report HCPCS codes for diabetes outpatient self-management training services under revenue code 51X.

When billing for these services, a copy of the provider's ERP certification must be submitted with his/her initial claim. Deductible and co-insurance are applicable.

Unique Physician Identification Number (UPIN)

Any service that is ordered or referred by a physician requires the ordering/referring physician's name and UPIN in blocks 17 and 17a on Form HCFA-1500. If submitting electronically, the UPIN of the ordering/referring physician goes in record FB1, field 13, and the name goes in record FB1, fields 10, 11, and 12.

Written Advance Notice Requirements

Providers are liable for denials that are the result of lack of certification, and denials when the services are rendered outside the certification period. In these situations, the beneficiary cannot be held liable for denials; therefore, no written advance notice is needed. This applies to both assigned and non-assigned claims.

Other Medicare Covered Services for Diabetic Patients

In addition to the diabetes outpatient self-management training services, Medicare covers medical equipment that can be utilized by patients to monitor blood sugar level and to maintain a constant insulin level.

Prior to the implementation of Section 4105 of the BBA, Medicare covered blood glucose monitors and its associated accessories and supplies only when the patient was diagnosed as an insulin-dependent diabetic. Effective July 1, 1998, Medicare coverage was extended to non-insulin dependent diabetics.

Prior to April 1, 2000, Medicare payment was not made for an external insulin infusion pump. However, as of April 1, 2000, the existing non-coverage policy on this item is being revised to *limited* coverage, based on established medical necessity requirements.

For further information regarding Medicare's medical necessity requirements and claim filing information for the above-mentioned items, please contact your local Durable Medical Equipment Regional Carrier (DMERC). For the name, address, and telephone number of the DMERC in your area, please access the following Web site:

www.medicare.gov/contacts/contact1.asp

Prostate Cancer

Covered Medicare Screening Procedures

What is a Prostate Specific Antigen (PSA) Test?

PSA, a tumor marker for adenocarcinoma of the prostate, can predict residual tumor in the post-operative phase of prostate cancer. Three to six months after a radical prostatectomy, PSA is reported as providing a sensitive indicator of persistent disease. Six months following introduction of antiandrogen therapy, PSA is reported as capable of distinguishing patients with favorable response from those in whom limited response is anticipated.

PSA is not in itself a diagnostic test; however, once a diagnosis has been established, it serves as a marker to follow the progress of most prostate tumors. PSA also aids in managing prostate cancer patients and in detecting metastatic or persistent disease in patients following treatment.

PSA is of proven value in differentiating benign from malignant disease in men with lower urinary tract signs and symptoms (e.g., hematuria, slow urine stream, hesitancy, urgency, frequency, nocturia, and incontinence). It is also of value in men with palpably abnormal prostate glands on physical exam, and men with other laboratory or imaging studies that suggest the possibility of a malignant prostate disorder. PSA testing may also be useful in the differential diagnosis of men presenting with as yet undiagnosed disseminated metastatic disease.

The PSA blood test is not perfect; however, it is the best test currently available for early detection of prostate cancer. Since doctors started using this test, the number of prostate cancers found at an early, curable stage has increased. Since most men have normal test results, this is reassurance that they are unlikely to have prostate cancer, especially if their digital rectal exam (DRE) result is also negative.

What is a Screening Digital Rectal Examination (DRE)?

A screening digital rectal examination is a clinical exam of an individual's prostate for nodules or other abnormalities.

Prostate Cancer Screening Coverage Guidelines

Section 4103 of the Balanced Budget Act of 1997 provides for coverage of certain prostate cancer screening tests, subject to coverage, frequency, and payment limitations. Effective for services furnished on or after **January 1, 2000,** Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. Medicare covers both screening digital rectal examinations and screening prostate specific antigen tests.

- **Screening Digital Rectal Examinations (DRE)** are covered at a frequency of once every 12 months for men who have attainted age 50. This screening must be *performed* by a doctor of medicine or osteopathy or by a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. The screening provider must be authorized under state law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.

- **Screening Prostate Specific Antigen (PSA) Blood Tests** are covered at a frequency of once every 12 months for men who have attained age 50. This screening must be *ordered* by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. The screening provider must be authorized under state law to perform the examination, be fully knowledgeable about the beneficiary's medical condition, and be responsible for using the results of any examination (test) performed in the overall management of the beneficiary's specific medical problem.

Statutory Required Frequency Parameters

For Medicare male beneficiaries age 50 or older, "annual" frequency is determined in this manner: Once a beneficiary has received any/all of the covered prostate cancer screening tests/procedures, he may receive another (or all) of such tests/procedures after 11 full months have elapsed since the last covered screening. Counting begins with the month after the last exam. For example, if the last covered test were performed on February 25, 2000, counting would begin with the month of March 2000. The beneficiary would then be eligible for the next test on or after February 25, 2001 (the month after 11 full months have passed).

Procedure Codes and Descriptors

Medicare allows payment for the following procedure codes:

G0102 **Prostate cancer screening; digital rectal examination**

G0103 **Prostate cancer screening; prostate specific antigen test (PSA), total**

Diagnosis Requirements

There are no specific diagnosis requirements for prostate screening tests/procedures; however, if screening is the reason for the test/procedure, the appropriate screening ("V") diagnosis code must be chosen when billing Medicare.

Reasons for Denial

Following are some reasons that Medicare may deny prostate screening tests and procedures:

- Beneficiary does not meet specified statutory age for the test/procedure.
- Beneficiary has exceeded statutory required frequency parameters for the test/procedure.
- Beneficiary received a covered Evaluation and Management (E/M) service on the same day in which the DRE was performed (only the DRE will be denied; PSA will be covered). In this situation the E/M service would be covered and the DRE would be denied.

Payment Requirements for Carriers

The DRE screening exam is reimbursed based on the physician's fee schedule. Additionally, the deductible and co-insurance **are** applicable when this service is provided. The PSA screening test is reimbursed under the clinical laboratory fee schedule. The deductible and co-insurance are **not** applicable when this service is provided.

Payment Requirements for Intermediaries

When billing using Form HCFA-1450 or the electronic equivalent, the following billing requirements should be considered:

- **Applicable Bill Types.** The appropriate bill types are 12X, 13X, 14X, 22X, 23X, 42X, 52X, 71X, 73X, 83X, and 85X.
- **Coding Requirements.** Providers must report HCPCS codes for prostate screening under revenue code 30X for the DRE and 770 for the PSA.

The DRE screening exam is reimbursed based on a reasonable cost basis. Additionally, the deductible and co-insurance **are** applicable when this service is provided. The PSA screening test is reimbursed under the clinical diagnostic laboratory fee schedule. The deductible and co-insurance are **not** applicable when this service is provided.

UPIN Requirements

Any service that is ordered or referred by a physician requires the ordering/referring physician's name and UPIN in blocks 17 and 17a on Form HCFA-1500. If submitting electronically, the UPIN of the ordering/referring physician goes in record FB1, field 13, and the name goes in record FB1, fields 10, 11, and 12.


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